MDR Tracking Number: M5-04-3444-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 06-09-04.

The IRO reviewed office visits, electrical stimulation, manual therapy, chiropractic manipulation, therapeutic activity and mechanical traction rendered from 09-10-03 through 05-17-04 that were denied based upon "V".

The IRO determined that the office visit on 09-10-03 **was** medically necessary and all other treatment and services in dispute **were not** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-12-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of the EOB's for CPT code **97530 (6 DOS)** for dates of service 03-15-04 through 04-02-04. The requestor did not submit proof of submission for reconsideration or convincing evidence of carrier receipt of reconsideration request per Rule 133.308(f)(2)(3). No reimbursement is recommended.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of the EOB's for CPT code **98941 (11 DOS)** for dates of service 03-22-04 through 05-19-04.

The requestor did not submit proof of submission for reconsideration or convincing evidence of carrier receipt of reconsideration request per Rule 133.308(f)(2)(3). No reimbursement is recommended.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of the EOB's for CPT code **G0283 (4 DOS)** for dates of service 04-05-04 through 05-10-04.
The requestor did not submit proof of submission for reconsideration or convincing evidence of carrier receipt of reconsideration request per Rule 133.308(f)(2)(3). No reimbursement is recommended.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of the EOB's for CPT code **97140-25** for dates of service 05-10-04, 05-14-04 and 05-17-04.
The requestor did not submit proof of submission for reconsideration or convincing evidence of carrier receipt of reconsideration request per Rule 133.308(f)(2)(3). No reimbursement is recommended.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of the EOB's for CPT code **98940** and **97012** for dates of service 05-14-04 and 05-17-04. The requestor did not submit proof of submission for reconsideration or convincing evidence of carrier receipt of reconsideration request per Rule 133.308(f)(2)(3). No reimbursement is recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for date of service 09-10-03 in this dispute.

This Findings and Decision and Order are hereby issued this 13th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

August 10, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-3444-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: letter of medical necessity, office notes, daily progress notes, physical therapy notes, operative and radiology reports.
Information provided by Respondent: correspondence and designated doctor exams.
Information provided by Neurologist: office notes and nerve conduction study.

Clinical History:
The patient is a 46-year-old male who, on his job on ___, felt a painful "pop" in his back that worsened as the day progressed. By the end of the day, his legs were "going numb." He first saw his primary care doctor who administered a steroid shot, but then changed to a doctor of chiropractic who began chiropractic care, physical therapy and rehabilitation. The records show that he last saw this doctor on 09/03/03, and then changed to another chiropractor one week later, beginning on 09/10/03. Treatment then

consisted of more chiropractic care, physical therapy and rehabilitation.

Disputed Services:
Office visit, electrical stimulation, manual therapy, chiropractic manipulation, therapeutic activity, and mechanical traction during the period of 09/10/03 through 05/17/04.

Decision:
The reviewer partially agrees with the determination of the insurance carrier and is of the opinion that the office visit on 09/10/03 was medically necessary. All other treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:
In this case, the patient's original treating doctor opted to discontinue treating workers' compensation patients, so it was reasonable for him to present to a new doctor for management of his condition until MMI. Therefore, the medical necessity of an initial evaluation is reasonable.

However, after review of the medical records submitted, it is determined that the doctor of chiropractic who provided treatment during the time frame in dispute offered nothing additional to what had already been tried (and had failed) prior to his initiation of care. In the treating doctor's letter of medical necessity, he referred to the previous doctor of chiropractic's care and stated that the care was delivered "sporadically and intermittently," and that "no active rehabilitation was performed [either]." However, the documentation submitted showed that the patient received regular scheduled care from 04/28/03 through 09/03/03, totaling 53 visits, and underwent therapeutic exercise (97110) by participating in nine 2-hour sessions and one, 1-hour session from 08/14/03 through 08/29/03, right before this new treating doctor commenced his care. Therefore, there was no basis to continue a therapy that was not providing significant benefit.

In addition, the records submitted from this treating doctor failed to include any re-examinations to warrant and justify continued care. The 1996 TWCC Medical Fee Guideline provides Medicine Ground Rules on page 31. Section I, A, identifies the criteria that must be met for physical medicine treatment to qualify for reimbursement: (1) the patient's condition shall have the potential for restoration of function and (2) the treatment shall be specific to the injury and provide for the potential improvement of the patient's condition. Potential for restoration of function is identified by progressive return to function. Without demonstration of objective progress, ongoing treatment could not have been reasonably expected to restore this patient's function and thus can only be deemed medically unnecessary.

Sincerely,